

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: MHL036-383	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 05/27/2025
NAME OF PROVIDER OR SUPPLIER POSITIVE POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 3061 CRAWFORD AVENUE GASTONIA, NC 28052		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	<p>INITIAL COMMENTS</p> <p>A limited follow up survey for the Type A1 was completed on May 27, 2025. This was a limited follow up survey, only 10A NCAC 27G .0209 Medication Requirements (V118) and 10A NCAC 27G .0209 Medication Requirements (V121) were reviewed for compliance. The following were brought back into compliance: 10A NCAC 27G .0209 Medication Requirements (V118) and 10A NCAC 27G .0209 Medication Requirements (V121). No deficiencies were cited.</p> <p>This facility is licensed for the following service category: 10A NCAC 27G .1700 Residential Treatment Staff Secure for Children or Adolescents.</p> <p>This facility is licensed for 3 and has a current census of 3. The survey sample consisted of audits of 3 current clients.</p>	V 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE